MYOBLOC®
rimabotulinumtoxinB
Injection [5,000 Units/mL]
Service & Support

Reimbursement Support Program

Enrollment Form

Phone: **1-888-461-2255 (Option 3)** Fax: **1-888-343-3275**

9:00 AM - 6:00 PM Eastern Time Monday - Friday

PLEASE READ: Patient's written consent has been obtained to release patient information to this program to facilitate the insurance verification process: ☐ Yes ☐ No (If no, please obtain consent before submitting this form)

Physician Information

Physician Name: ____________________

Practice/Facility Name: ____________________

Address 1: ____________________

Address 2: ____________________

City: __________ State: ____ ZIP: ______

Telephone: __________ Fax: __________

Email: ____________________

Name of Individual Completing Form: ____________________

Tax ID: __________ DEA: __________

Insurance Information (Primary)

☐ Medicare ☐ Medicaid ☐ Commercial

☐ Worker's Compensation ☐ Champus/TriCARE

Insurance Information Detail (Primary)

Name of Insurance Company: ____________________

Address: ____________________

City: __________ State: ____ ZIP: ______

Telephone: __________ Fax: __________

Policy Holder's Name: ____________________

Policy Holder's Date of Birth: ____________________

Policy Holder's SSN: ____________________

Relationship to Patient: ____________________

Policy #: __________ Group #: __________

Employer's Name: ____________________

Physician Insurance Provider/NPI #:
(Required for interaction with insurance company): ____________________

Is physician a participating or non-participating provider?
(Please check one): ☐ Participating ☐ Non-Participating

Treatment Information

Site of Service: ☐ Physician's Office ☐ ASC

☐ Hospital Outpatient ☐ Hospital Inpatient

☐ Other

Diagnosis Code 1: ____________________

Diagnosis Code 2: ____________________
(ICD-9 Code May Only Be Assigned By Physician)

Patient Information

Patient Name: ____________________

Sex: ☐ Male ☐ Female

Date of Birth: ____________________

SSN: ____________________

Address 1: ____________________

Address 2: ____________________

City: __________ State: ____ ZIP: ______

Telephone: __________ Fax: __________

Email: ____________________

Insurance Information (Secondary)

☐ Medicare ☐ Medicaid ☐ Commercial

☐ Worker's Compensation ☐ Champus/TriCARE

Insurance Information Detail (Secondary)

Name of Insurance Company: ____________________

Address: ____________________

City: __________ State: ____ ZIP: ______

Telephone: __________ Fax: __________

Policy Holder's Name: ____________________

Policy Holder's Date of Birth: ____________________

Policy Holder's SSN: ____________________

Relationship to Patient: ____________________

Policy #: __________ Group #: __________

Employer's Name: ____________________

Physician Insurance Provider/NPI #:
(Required for interaction with insurance company) ____________________

Is physician a participating or non-participating provider?
(Please check one): ☐ Participating ☐ Non-Participating

Treatment Information

EMG Code: ____________________

CPT Code: ____________________

Date of Service: (If known): ____________________

Patient Dosage:

Number of Vials: ______ Vial Sizes: ______

SOLSTICE®
NEUROSCIENCES
A US WORLDMEDS COMPANY

PLEASE READ DECLARATION BEFORE SIGNING

PATIENT DECLARATION

I certify that the information provided in this application is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Solstice Neurosciences LLC ("Solstice") Reimbursement Support Program. I hereby provide my consent to permit my physician to release patient identification, insurance and medical information about me to the Solstice Reimbursement Support Program including any other information necessary to evaluate my insurance coverage for MYOBLOC® (rimabotulinumtoxinB) Injection and to complete the verification process. I further provide my consent to permit the Program to obtain insurance coverage information from my employer or insurance company, and to obtain any other information about me necessary to complete the verification process, assess eligibility, verify continuing eligibility, or verify accuracy of any information provided in this application. I understand such information is for the sole use of Solstice, its representatives and/or agents for the purpose of assessing my insurance coverage for treatment with MYOBLOC. I understand that my information will not be shared with any third parties except as necessary for my participation in the Program, except as otherwise required by law. This authorization will remain in effect until I no longer need assistance from the MYOBLOC Reimbursement Support Program or until I revoke the authorization by calling a MYOBLOC Reimbursement Support Program representative at 888-461-2255 or by sending a fax to 888-343-3275 stating my revocation.

I understand that there is no guarantee that my insurance company will reimburse for MYOBLOC® (rimabotulinumtoxinB) Injections. I also understand that the Program reserves the right at any time, and without notice: to modify the form; to modify or discontinue any or all aspects of the Program; or to terminate assistance under the Program at any time.

Reimbursement services are available only for those patients being treated with MYOBLOC® (rimabotulinumtoxinB) Injection for a therapeutic condition for which there is a reasonable expectation for reimbursement from a third-party payer.

I have indicated my agreement with these terms by signing below.

____
Patient Name (Printed)

____
Patient Signature Date

PHYSICIAN DECLARATION

I agree to communicate Program information as provided by Solstice Neurosciences, LLC ("Solstice") to my patients upon request. I understand that there is no guarantee that insurers will reimburse for MYOBLOC® (rimabotulinumtoxinB) Injection.

I understand that I am under no obligation to prescribe any Solstice drug, nor will I receive any benefit from Solstice or its representatives and/or agents, for prescribing a Solstice drug. I understand that Solstice and its representatives and/or agents are not responsible for filing any insurance claims on my or my patient's behalf. I agree to abide by this declaration throughout my participation in the Program and to notify a Program representative immediately if any aspects of my certification are no longer applicable. I have read the declaration signed by my patient and understand and agree to the terms and conditions of this Program contained therein. I agree to release to Solstice information my patient has consented to be released.

____
Physician Name (Printed)

____
Physician Signature Date

FAX COMPLETED FORM TO: 1-888-343-3275

MYOBLOC is a registered trademark of Solstice Neurosciences, LLC,
a wholly-owned subsidiary of US WorldMeds, LLC.
© 2011 US WorldMeds, LLC
USWM-MYO467-0211

SOLSTICE®
NEUROSCIENCES
A US WORLDMEDS COMPANY